(2) *Therapeutic leave.* A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the nursing facility if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a nursing facility the nursing facility's current per diem rate on file with the Department for a therapeutic leave day.

§ 1187.105. Limitations on payment for prescription drugs.

The Department's per diem rate for nursing facility services does not include prescription drugs. Prescribed drugs for the categorically needy and medically needy are reimbursable directly to a licensed pharmacy in accordance with Chapter 1121 (relating to pharmaceutical services).

§ 1187.106. Limitations on payment during strike or disaster situations requiring resident evacuation.

Payment may continue to be made to a nursing facility that has temporarily transferred residents, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the residents' needs, if the institution receiving the residents is licensed and certified to provide the required services. If the nursing facility transferring the residents can demonstrate that there is no certified nursing facility available for the safe and orderly transfer of the residents, the payments may be made so long as the institution receiving the residents is certifiable and licensed to provide the services required. The resident assessment submissions for the transferring nursing facility residents shall be maintained under the transferring nursing facility provider number as long as the transferring nursing facility is receiving payment for those residents. If the nursing facility to which the residents are transferred has a different per diem rate, the transferring nursing facility shall be reimbursed at the lower rate. The per diem rate established on the date of transfer will not be adjusted during the period that the residents are temporarily transferred. The nursing facility shall immediately notify the Department in writing of an impending strike or a disaster situation and follow with a listing of MA residents and the nursing facility to which they will be or were transferred.

§ 1187.107. Limitations on resident care and other resident related cost centers.

(a) The Department will set a limit on the resident care peer group price for each nursing facility for each year, using the NIS database as specified in § 1187.91 (relating to database), to the lower of:

(1) The nursing facility resident care peer group price.

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(2) One hundred three percent of the nursing facility's average case-mix neutralized resident care cost per diem plus 30% of the difference between the 103% calculation and the nursing facility resident care peer group price.

(b) The Department will set a limit on the other resident related peer group price for each nursing facility for each base year, using the NIS database as specified in § 1187.91 to the lower of:

(1) The nursing facility other resident related peer group price.

(2) One hundred three percent of the nursing facility average other resident related cost per diem plus 30% of the difference between the 103% calculation and the nursing facility other resident related peer group price.

§ 1187.108. Gross adjustments to nursing facility payments.

(a) The case-mix payment system is a prospective system. There is no cost settlement under the case-mix payment system.

(b) Certain adjustments may be made which increase or decrease the payment which a nursing facility may have otherwise received. Gross adjustments to nursing facility payments are based on one or more of the following general provisions:

(1) If audit findings result in changing the peer group median and the peer group price, a retrospective gross adjustment is made for each nursing facility in the peer group where the change occurred.

(2) If a nursing facility's MA CMI changes as a result of UMR resident assessment audit adjustments, retrospective gross adjustments shall be made for the nursing facility involved.

(c) Specific adjustments of the gross payments received by a nursing facility may be required by §§ 1187.109 - 1187.115.

§ 1187.109. Medicare upper limit on payment.

Nursing facilities shall submit Medicare information on the MA-11. MA payments will not exceed in the aggregate the comparable amount that Medicare would have paid had the Medicare Program reimbursed for the services rendered.

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§ 1187.110. Private pay rate adjustment.

The MA rate is limited by the nursing facility's private pay rate for the comparable rate period.

§ 1187.111. Disproportionate share incentive payments.

(a) A disproportionate share incentive payment will be made based on MA paid days of care times the per diem incentive to facilities meeting the following criteria for a 12-month facility cost reporting period:

(1) The nursing facility shall have an annual overall occupancy rate of at least 90% of the total available bed days.

(2) The nursing facility shall have an MA occupancy rate of at least 80%. The MA occupancy rate is calculated by dividing the MA days of care paid by the Department by the total actual days of care.

(b) The disproportionate share incentive payments will be based on the following for year one of implementation:

	Overall Occupancy	MA Occupancy (y)	Per Diem Incentive
Group A	90%	$\geq$ 90% y	$2.50
Group B	90%	88% $\leq$ y <90%	$1.70
Group C	90%	86% $\leq$ y <88%	$1.00
Group D	90%	84% $\leq$ y <86%	$0.60
Group E	90%	82% $\leq$ y <84%	$0.30
Group F	90%	80% $\leq$ y <82%	$0.20

(c) For each year subsequent to year 1 of implementation, disproportionate share incentive payments as described in subsection (b) will be inflated forward using the Health Care Financing Administration Nursing Home Without Capital Market Basket Index to the end point of the rate setting year for which the payments are made.

(d) These payments will be made annually within 120 days after the submission of an acceptable cost report provided that payment will not be made before 210 days of the close of the nursing facility fiscal year.

(e) For year 1 of implementation only, facilities with a June 30 cost report year end will receive a disproportionate share payment based on the January 1 through June 30 time period.

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(f) For the period January 1, 2000, to June 30, 2003, the disproportionate share incentive payment to qualified nursing facilities shall be increased to equal two times the disproportionate share per diem incentive calculated in accordance with subsection (c).

(1) For the period commencing January 1, 2000, through June 30, 2000, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 1999, or June 30, 2000.

(2) For the period commencing July 1, 2000, through June 30, 2001, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2000, or June 30, 2001.

(3) For the period commencing July 1, 2001, through June 30, 2002, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2001, or June 30, 2002.

(4) For the period commencing July 1, 2002, through June 30, 2003, the increased incentive shall apply to cost reports filed for the fiscal period ending December 31, 2002, or June 30, 2003.

§ 1187.112. Cost per bed limitation adjustment.

(a) For year 1 of implementation the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $22,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be included in the $22,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $22,000 per bed limitation will be made. The full appraisal value will not be recognized.

(b) For year 2 of implementation and year 3 of implementation and thereafter the following cost per bed limitation adjustment will be made:

(1) The allowable capital costs will be limited to a maximum participation allowance cost per bed of $26,000. The cost per bed will be based on the capitalized cost of fixed property. The cost of movable property will not be included in the $26,000 per bed limit.

(2) When the appraisal value exceeds the cost per bed limitation, adjustment for the $26,000 per bed limitation will be made. The full appraisal value will not be recognized.

§ 1187.113. Capital component payment limitation.

(a) *Conditions.* The capital component payment for fixed property is subject to the following conditions:

(1) The Department will make the capital component payment for fixed property on new or additional beds only if one of the following applies:

(i) The nursing facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health by August 31, 1982.

(ii) The nursing facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility located within the county.

(2) The Department will not make the capital component payment unless the nursing facility substantially implements the project under 28 Pa. Code Chapter 401 within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) The capital component payment for replacement beds is allowed only if the nursing facility was issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.

(4) The Department will not make the capital component payment unless written approval was received from the Department prior to the construction of the new beds.

(b) *Capital cost reimbursement waivers.* The Department may grant waivers of subsection (a) to permit capital cost reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department will publish a statement of policy under § 9.12 (relating to statements of policy) specifying the criteria that it will apply to evaluate and approve applications for capital cost reimbursement waivers.

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§ 1187.113a. Nursing facility replacement beds-statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for replacement beds constructed, licensed or certified after November 29, 1997.

(b) *Purpose.*

(1) Department regulations relating to capital component payments for nursing facilities enrolled and participating in the Commonwealth's Medical Assistance (MA) Program state that capital component payments for replacement beds are allowed only if the nursing facility was "issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health." See § 1187.113(a)(3) (relating to capital component payment limitations).

(2) Chapter 7 and all other portions of the Health Care Facilities Act (35 P. S. §§ 448.701-448.712) pertaining to Certificates of Need (CON) sunsetted on December 18, 1996. To allow the Department to continue to make capital component payments for replacement beds for which a nursing facility does not have a CON or letter of nonreviewability, the Department will amend its regulations to specify the conditions under which it will recognize beds as replacement beds for purposes of making capital component payments. Pending the promulgation of these regulations, the Department has issued this section to specify instances in which the Department will make capital component payments for replacement beds.

(c) *Request for approval of replacement beds.* A nursing facility provider that intends to seek capital component payments under § 1187.113(a)(3) for nursing facility beds constructed, licensed or certified after November 29, 1997, shall submit a written request to the Department for approval of the beds as replacement beds.

(1) The facility shall submit an original and two copies of its request prior to beginning construction of the beds. If a facility began construction of the beds prior to November 29, 1997, the facility shall submit an original and two copies of its request by February 27, 1998, or the date on which the facility requested the Department of Health to issue a license for the beds, whichever date is earlier.

(2) A facility that fails to submit a request under paragraph (1) may not receive capital component payments for the beds.

(d) *Policy regarding approval of replacement beds.*

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(1) *Nursing facility beds authorized under a CON dated on or before December 18, 1996.*

(i) The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if the following conditions are met:

(A) The facility has a CON or letter of nonreviewability dated on or before December 18, 1996, authorizing the replacement bed project.

(B) The facility has "substantially implemented" its project, as defined in 28 Pa. Code § 401.2 (relating to definitions).

(C) The beds that are being replaced:

(I) Are currently certified.

(II) Are premoratorium beds.

(III) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(ii) If a facility has a CON dated on or before December 18, 1996 authorizing a replacement bed project, but the facility fails to substantially implement its project as defined in 28 Pa. Code § 401.2, the Department will treat the facility as though it does not have a CON, and consider the facility's request under paragraph (2).

(2) *Nursing facility beds not authorized by a CON dated on or before December 18,1996.* The Department will approve replacement beds as qualifying for capital component payments under § 1187.113(a) if, after applying the guidelines set forth in subsection (e), the Department determines that the following conditions are met:

(i) Construction of the replacement beds is necessary to assure that MA recipients have access to nursing facility services consistent with applicable law. If the Department determines that some, but not all, of the replacement beds are necessary to assure that MA recipients have appropriate access to nursing facility services, the Department may limit its approval to the number of beds it determines are necessary. If the Department limits its

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approval to some of the beds, the remaining unapproved beds will not qualify for capital component payments.

(ii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be constructed within a 1-mile radius of the existing structure in which the beds that are being replaced are situated.

(iii) Unless the Department finds that exceptional circumstances exist that require the replacement beds to be located at a further distance from the existing structure, the replacement beds will be attached or immediately adjacent to the existing structure in which beds that are being replaced are situated if the replacement beds will replace only a portion of the beds in the existing structure.

(iv) The beds that are being replaced:

(A) Are currently certified.

(B) Are premoratorium beds.

(C) Will be decertified and closed permanently effective on the same date that the replacement beds are certified.

(e) *Guidelines for evaluation of requests to construct replacement beds.* The Department will use the following guidelines, and will consider the following information, as relevant in determining whether to approve replacement beds under subsection (d)(2).

(1) Whether, and to what extent, construction of all the replacement beds is required to ensure the health, safety and welfare of the residents of the facility.

(2) Whether, and to what extent, building code violations or other regulatory violations exist at the facility requiring the construction of all of the replacement beds. If the provider alleges these violations, it shall attach waivers from the relevant regulatory agencies, and explain why the waivers of code violations may not continue indefinitely.

(3) Whether, and to what extent, the facility has considered the development of home and community-based services in lieu of replacing some or all of its beds.

(4) Whether other support services for MA recipients, including home and community-based services, are available in lieu of nursing facility services.

(5) Whether the overall total occupancy and MA occupancy levels of the facility and facilities in the county indicate that there is a need for all or a portion of the replacement beds.

(6) If the provider is proposing to construct a new facility or wing, whether the provider has satisfactorily demonstrated that it would be more costly to renovate the provider's current facility rather than to construct the new facility or wing.

(7) Whether the facility, or section of the facility, which currently contains the beds to be replaced is able to be utilized for another purpose.

(f) *Definitions.* The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise:

Premoratorium beds - Nursing facility beds that were built under an approved CON dated on or before August 31, 1982, and for which the Department is making a capital component payment under these regulations.

Replacement beds - Nursing facility beds constructed in a new building or structure that take the place of existing beds located in a separate or attached building or structure; or reconstructed or renovated beds within an existing building or structure when the cost of the reconstruction or renovation equals or exceeds 50% of the total facility's appraised value in effect for the rate period in which the request is made.

§ 1187.113b. Capital cost reimbursement waivers - statement of policy.

(a) *Scope.* This section applies to any participating provider of nursing facility services that intends to seek capital component payments under this chapter for existing postmoratorium beds in a nursing facility. This section also applies to participating providers who were granted moratorium waivers under Chapter 1181 (relating to nursing facility care).

(b) *Purpose.* The purpose of this section is to announce the criteria that the Department will apply to evaluate and approve applications for capital cost reimbursement waivers of § 1187.113(a) (relating to capital component payment limitation) and to reaffirm that nursing facilities that were granted waivers under Chapter 1181 continue to receive capital component payments under this chapter. Waivers of § 1187.113(a) will not otherwise be granted except as provided in this section.

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(c) *Submission and content of applications.*

(1) An applicant seeking a waiver of § 1187.113(a) shall submit a written application and two copies to the Department at the following address:

Department of Public Welfare
Bureau of Long Term Care Programs
P.O. Box 2675
Harrisburg, PA 17105-2675
ATTN: MORATORIUM WAIVER REVIEW

(2) The written application shall address the criteria in subsections (d) and (e). If necessary, the application should include supporting documentation.

(d) *Policy regarding additional capital reimbursement waivers.* Section 1187.113(b) authorizes the Department to grant waivers of §1187.113(a) to permit capital reimbursement as the Department in its sole discretion determines necessary and appropriate. The Department has determined that a waiver of § 1187.113(a) will only be necessary and appropriate when the Secretary or a designee finds that the waiver is in the Department's best interests and will serve to promote the Commonwealth's policy to encourage the growth of home and community-based services available to MA recipients.

(1) The Department will find that a waiver serves to promote the Commonwealth's policy to encourage the growth of MA home and community-based services only if the Department concludes that the following criteria are met:

(i) The application for a waiver is made by or on behalf of a person who has been the legal entity of two MA participating nursing facilities that meet the following conditions:

(A) Have both been owned by the legal entity for at least 3 consecutive years prior to the date of application.

(B) Serve residents from the same primary service area.

(C) Have each maintained an average MA occupancy rate that exceeds the Statewide MA occupancy rate for 3 consecutive years prior to the date of the application.

(D) Are identified in the application.

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